Board of Addiction and Prevention Professionals (BAPP)
3101 West 41st Street, Suite 205, Sioux Falls, SD 57105
Phone: 605-332-2645 Fax: 605-332-6778 Email: bapp@midconetwork.com
Web: www.dss.sd.gov/behavioralhealthservices/licensingboards

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Transition Application to LAC or CAC

This application may be submitted at any time prior to July 1, 2014.

Check One	Transition
	From CCDC III to LAC (complete this page only)
	From CCDC II to CAC (complete this page only)
	From CCDC II to LAC (complete both pages of this application and submit official transcripts showing proof of degree)

PERSONAL DATA:

Name: ____
First Middle Last Maiden

Home Address: ____

City: ___________________________________ State: ____________ Zip: ____________________

Home Phone: ______________________________ Cell Phone: _________________________________

Home Email: ______________________________ Work Email: _________________________________

Work Phone: ______________________________ Work Fax: ___________________________________

Certification level (check one): CCDC II ______ CCDC III ______

Date of initial certification: ____________________ **Certificate Number:** ________________________

CURRENT EMPLOYMENT:

Agency Name: ____

Agency Mailing Address: ____

City: ___________________________________ State: ____________ Zip: ____________________

Job Title: ____

Name of Supervisor: ____

Please print your name below as you would like it to appear on your certificate / license.

Printed name: ____

____ _________________________
Signature Date

Work Experience Verification

Transition Application to LAC or CAC

<u>Applicant</u>: All work experience following initial certification must be verified. Make a copy of this form for each agency where you completed work experience. Complete the top section and send the form to all agencies for verification of your work experience.

Applicant's Name: _____

Address: _____

City: _____State: _____ Zip: _____

Job Title: _____

Certification level (check one): CCDC II _____ CCDC III _____

Date of initial certification: _____ Certificate Number: _____

Dates of Employment – From: _____ To: _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

APPLICANT STOP HERE

THE FOLLOWING MUST BE COMPLETED BY THE AGENCY

The applicant listed above is making application through the Board of Addiction and Prevention Professionals (BAPP). Please verify the work experience for this individual and return this form directly to the BAPP, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105. If the above information is not correct, please make changes and place your initials beside the changes.

I hereby attest that the above information is true and correct. This person was involved in the supervised counseling of diagnosed alcohol and drug abuse clients with the majority of their time spent in individual, group and/or family counseling; and, the remaining experience was related to the AODA Counselor Core Functions.

Name: _____ Title: _____

Name of Agency: _____

Agency Address: _____

City: _____ State: _____ Zip:_____

Work Phone: _____

Number of years of qualifying work experience following initial certification: _____
(See initial certification date above)

_____ _____
Signature Date